EXECUTIVE SUMMARY

PURPOSE

This inspection determined how different billing practices, financial arrangements, and clinical settings affect the cost of imaging services for the Medicare program and its beneficiaries.

BACKGROUND

Nursing homes* arrange for ancillary services--such as x-rays--for patients who require them. In some instances, firms known as ***portable x-ray suppliers*** provide the x-ray and electrocardiogram (EKG) services in nursing homes.** Imaging services consist of several components--technical, professional, transportation, and setup--depending on (a) the type of service and (b) where and by whom it is rendered.

Portable x-ray and EKG services provided to nursing home patients may be billed either by a skilled nursing facility to the Part A fiscal intermediary or by the portable supplier to the Part B carrier. ***"Direct billing"*** occurs when the portable supplier bills the carrier. ***"Billing under arrangement"*** occurs when, based on a contractual agreement, a skilled nursing facility bills the fiscal intermediary and pays the portable supplier for services rendered. Skilled nursing facilities may bill under arrangement even for patients who are not in Part A-covered stays.

We examined a stratified random sample of 729 imaging services that were provided while the beneficiaries were nursing home residents in 1994.

FINDINGS

Overall, we found that Medicare pays too much for portable imaging services. Medicare could save as much as $66 million in 1 year and $361 million over 5 years, based on the following findings and recommendations:

Portable chest x-rays cost far more than non-portable chest x-rays

Portable chest x-rays may cost up to nine times more than non-portable chest x-rays. Portable x-ray suppliers performed more than 60 percent of chest x-rays rendered to

---

* For purposes of this inspection, *nursing homes* refers to skilled nursing, Medicaid nursing, board and care, assisted living, and retirement facilities collectively. Where appropriate, we distinguish between skilled nursing facilities and these other facilities.

** Other options for nursing homes include providing the service with their own equipment or transporting patients to hospital outpatient departments, imaging centers, physician offices, or other facilities for x-rays or EKGs.

nursing home residents in 1994. In general, portable chest x-rays cost more because Medicare allows a transportation charge, which comprises most of the cost of the service.

Medicare pays more than twice as much for imaging services when they are billed under arrangement rather than when payment is limited to the fee schedule

In 1994, Medicare paid $14.7 million more for portable chest x-rays and EKGs provided under arrangement than it would have if payment were limited to the carrier fee schedules. This occurs because (1) portable x-ray suppliers negotiate contracts with skilled nursing facilities to ensure that they receive as much as six times more than fee schedules would allow and (2) skilled nursing facilities mark up these already inflated charges as much as 250 percent for overhead and expenses. In addition, we estimate that Medicare spent $9 million more in 1994 on other radiological services billed under arrangement than it would have if payments for those services had been limited by the fee schedules.

On average, portable suppliers who bill under arrangement receive double what the fee schedule would allow

Portable x-ray suppliers negotiate contracts with skilled nursing facilities to receive more (as much as six times more) than the Medicare fee schedule would allow. Portable x-ray suppliers charge radically different amounts to neighboring skilled nursing facilities.

Skilled nursing facilities receive millions of dollars that they would not receive if they did not bill under arrangement

Skilled nursing facilities mark up portable chest x-ray costs as much as 250 percent above what portable x-ray suppliers bill them. This totaled $8.1 million in 1994.

Medicare pays for services under arrangement that it would not cover if billed directly

Services billed under arrangement are not subjected to the same routine screens and edits as directly billed services are. As a result, skilled nursing facilities are reimbursed for charges that would be denied if the portable supplier billed directly. These reimbursements include (1) setup charges for portable EKG equipment, (2) after-hours or emergency charges, (3) transportation charges not prorated when multiple patients are seen, (4) medically unnecessary or duplicate services, and (5) portable equipment transportation and setup charges when only a portable technician is provided.

Beneficiaries' copayments for services billed under arrangement are almost three times more than they would be if the services had been billed directly

The combination of three factors--inflated supplier charges to skilled nursing facilities, excessive markups by these facilities, and the Medicare policy that beneficiary copayments are 20 percent of *billed* amounts for ancillary services--results in vastly higher costs to beneficiaries and secondary payers.

The amounts that Medicare carriers allow for transportation of portable x-ray equipment vary widely, and some are excessive

In 1994, carrier allowances for portable x-ray transportation when one patient was seen ranged from $10.00 to $186.39. Although Medicare requires carriers to prorate transportation charges when multiple patients are seen at one nursing home, not all carriers do this correctly. There is no statutory authority for the Health Care Financing Administration (HCFA) to allow setup charges. The HCFA recently used the lack of statutory authority as a rationale for eliminating reimbursement for EKG transportation.

RECOMMENDATION

In the draft of this report, we recommended that HCFA:

- *instruct fiscal intermediaries to never pay more than the fee schedule amount for portable imaging services billed under arrangement;*
- *require fiscal intermediary edits and Common Procedure Coding System codes on all claims to discontinue payments for non-covered services;*
- *require fiscal intermediaries to disallow any skilled nursing facility overhead associated with portable imaging services; and*
- *convert transportation reimbursement rates to a national fee schedule, rebundle equipment setup with transportation, and remind carriers that they must prorate transportation charges when multiple patients are seen at the same facility.*

We projected 5-year Medicare savings of $360.9 million for these recommendations, as indicated in the following table:

Projected Medicare savings from implemented recommendations		
Option	1-year savings	5-year savings
Limit payment for services billed under arrangement to fee schedule	$ 28.3 million	$160.4 million
Limit transportation to $70 per beneficiary-service day (the national median), $35 if 2 beneficiaries are seen during the same trip, etc.	$ 21.8 million	$126.6 million
Stop paying for setup	$ 15.7 million	$ 73.9 million
TOTALS	**$ 65.8 million**	**$360.9 million**

The HCFA concurred with the majority of the recommendations in our draft report but did not concur with our recommendations that it (1) disallow any skilled nursing facility overhead associated with portable imaging services and (2) rebundle the equipment setup charge with transportation.

After we released our draft report, President Clinton signed into law the Balanced Budget Act of 1997. Among the provisions in this law, it (1) establishes a prospective payment system for beneficiaries in Part A-covered stays in skilled nursing facilities, to be phased in over several years; (2) requires that all Part B items and services furnished to residents of nursing homes (not covered under Part A) be billed by the nursing homes as part of a consolidated billing system; (3) limits reimbursement for services paid under consolidated billing to the Part B fee schedule; and (4) requires HCFA Common Procedure Coding System codes for services provided to skilled nursing facility patients that are billed to fiscal intermediaries.

We believe that implementation of the Balance Budget Act will address our findings and the intent of our recommendations. We are concerned, however, that the cost of ancillary services has been inflated by the practices described in this report. Therefore, we recommend that HCFA:

- ***take into account the inflated payments that have been made for portable imaging services when it implements the prospective payment and Part B provisions of the Balanced Budget Act, seeking legislative authority if necessary.***

  The HCFA should take into account the inflated charges for (1) services billed under arrangement (including payments for services that were non-covered) and (2) transportation charges that were excessive or prorated incorrectly.

Operation Restore Trust

In May 1995, President Clinton and Health and Human Services Secretary Donna Shalala announced the kickoff of Operation Restore Trust (ORT), a crackdown on Medicare and Medicaid fraud, waste, and abuse in home health agencies, nursing homes, and durable medical equipment suppliers. The ORT focused on the five States--California, New York, Florida, Texas, and Illinois--that account for 40 percent of the nation's Medicare beneficiaries and program expenditures. This was an ORT inspection. A companion report, "Portable Imaging Services: Nursing Home Perspectives" (OEI-09-95-00091), describes when, how, and why nursing homes use portable imaging services. Another companion report, "Imaging Services for Nursing Home Patients: Medical Necessity" (OEI-09-95-00092), assesses the medical necessity and quality of care.